# FAQs About The HIPAA Nondiscrimination Requirements

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## Under HIPAA, an individual cannot be denied eligibility for benefits or charged more for coverage because of any health factor. What are the "health factors"?

They are:

- health status;
- medical condition, including both physical and mental illnesses;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability; and
- disability.

The term "evidence of insurability" includes conditions arising from acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

## Can a group health plan require an individual to pass a physical examination in order to be eligible to enroll in the plan?

No. A group health plan may not require an individual to pass a physical exam for enrollment, even if the individual is a late enrollee.

## Can a plan require an individual to complete a health care questionnaire in order to enroll?

Yes, provided that the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

## Can plans exclude or limit benefits for certain conditions or treatments?

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination that the benefits are experimental or medically unnecessary - but only if the benefit restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.)

Compliance with HIPAA's nondiscrimination provisions does not in any way reflect compliance with any other provision of ERISA (including COBRA and ERISA's fiduciary provisions). Nor does it reflect compliance with other State or Federal laws (such as the Americans with Disabilities Act).

## Can a plan deny benefits otherwise provided for the treatment of an injury based on the source of that injury?

If the injury results from a medical condition or an act of domestic violence, a plan may not deny benefits for the injury - if it is an injury the plan would otherwise cover.

For example, a plan may not exclude coverage for self-inflicted injuries (or injuries resulted from attempted suicide) if the individual's injuries are otherwise covered by the plan and if the injuries are the result of a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or domestic violence, such as injuries sustained in high risk activities (for example, bungee jumping). But the plan could not exclude an individual from enrollment for coverage because the individual participated in bungee jumping.

## Can a plan charge individuals with histories of high claims more than similarly situated individuals based on their claims experience?

No. Group health plans cannot charge an individual more for coverage than other similarly situated individuals based on any health factor.

## How are groups of similarly situated individuals determined?

Distinctions among groups of similarly situated participants in a health plan must be based on bona-fide employment-based classifications consistent with the employer's usual business practice. Distinctions cannot be based on any of the health factors noted earlier.

For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as distinct groups of similarly situated individuals, with different eligibility provisions, different benefit restrictions, or different costs, provided the distinction is consistent with the employer's usual business practice.

In addition, a plan generally may treat participants and beneficiaries as two separate groups of similarly situated participants. The plan also may distinguish between beneficiaries based on, for example, their relationship to the plan participant (such as spouse or dependent child) or based on the age or student status of dependent children.

In any case, a plan cannot create or modify a classification directed at individual participants or beneficiaries based on one or more of the health factors.

## Is it permissible for a health insurance issuer to charge a higher premium to one group health plan (or employer) that covers individuals, some of whom have adverse health factors, than it charges another group health plan comprised of fewer individuals with adverse health factors?

Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer.

## Can a health insurance issuer charge an employer different premiums for each individual within a group of similarly situated individuals based on each individual's health status?

No. Issuers may not charge or quote an employer or group health plan separate rates that vary for individuals (commonly referred to as "list billing"), based on any of the health factors.

This does not prevent issuers from taking the health factors of each individual into account when establishing a blended, aggregate rate for providing coverage to the employment-based group overall. The issuer may then charge the employer (or plan) a higher overall rate, or a higher blended per-participant rate.

While HIPAA prohibits list billing based on health factors, it does not restrict communications between issuers and employers (or plans) regarding the factors considered in the rate calculations.

## Can a group health plan impose a nonconfinement clause (e.g., a clause stating that if an individual is confined to a hospital at the time coverage would otherwise take effect, coverage would not begin until that individual is no longer confined)?

No. A group health plan may not deny or delay an individual's eligibility, benefits, or the effective date of coverage because that individual is confined to a hospital or other health care facility. In addition, a health plan may not set an individual's premium rate based on that person's confinement.

## Can a group health plan impose an "actively-at-work" provision (e.g., a requirement that an employee be actively at work after a waiting period for enrollment in order to have health coverage become effective on that day)?

No. Generally a group health plan may not refuse to provide benefits because an individual is not actively at work on the day that individual would otherwise become eligible for benefits. However, plans may have actively-at-work clauses if the plan treats individuals who are absent from work due to a health factor (for example, individuals taking sick leave) as if they are actively at work for purposes of health coverage.

Plans may require individuals to report for the first day of work before coverage may become effective. In addition, plans may distinguish among groups of similarly situated individuals in their eligibility provisions. For example, a plan may require an individual to work full time, such as 250 hours per quarter or 30 hours per week to be eligible for health plan coverage.

## Is it permissible for a group health plan that generally provides coverage for dependents only until age 25 to continue health coverage past that age for disabled dependents?

Yes, a plan can treat an individual with an adverse health factor more favorably by offering extended coverage.

## Are wellness programs allowed under HIPAA's nondiscrimination rules?

The HIPAA nondiscrimination provisions generally prohibit group health plans from charging similarly situated individuals different premiums or contributions or imposing different deductible, copayment or other cost sharing requirements based on a health factor. However, there is an exception that allows plans to offer wellness programs.

If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard related to health factor, or if no reward is offered, the program complies with the nondiscrimination requirements (assuming participation in the program is made available to all similarly situated individuals). For example:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation rather than outcomes.
- A program that encourages preventive care by waiving the copayment or deductible requirement for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly health education seminar.

Wellness programs that condition a reward on an individual satisfying a standard related to a health factor must meet five requirements described in the final rules in order to comply with the nondiscrimination rules.

The wellness program rules are generally effective for the plan year starting on or after July 1, 2007.

## What are the five requirements for wellness programs which base a reward on satisfying a standard related to a health factor?

1. The total reward for all the plan's wellness programs that require satisfaction of a standard related to a health factor is limited – generally, it must not exceed 20 percent of the cost of employee-only coverage under the plan. If dependents (such as spouses and/or dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled.
2. The program must be reasonably designed to promote health and prevent disease.
3. The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.
4. The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard.
5. The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard).

## How do the wellness program rules apply to a group program that offers a reward to individuals who participate in voluntary testing for early detection of health problems? The plan does not use the test results to determine whether an individual receives a reward or the amount of an individual's reward.

The plan's program does not base any reward on the outcome of the testing. Thus, it is allowed under the HIPAA nondiscrimination provisions without being subject to the five requirements for wellness programs that do require satisfaction of a standard related to a health factor.

## Can a plan provide a premium differential between smokers and nonsmokers?

The plan is offering a reward based on an individual's ability to stop smoking.

Medical evidence suggests that smoking may be related to a health factor. *The Diagnostic and Statistical Manual of Mental Disorders*, which states that nicotine addiction is a medical condition, supports that position. In addition, a report of the Surgeon General adds that scientists in the field of drug addiction agree that nicotine, a substance common to all forms of tobacco, is a powerfully addictive drug.

For a group health plan to maintain a premium differential between smokers and nonsmokers and not be considered discriminatory, the plan's nonsmoking program would need to meet the five requirements for wellness programs that require satisfaction of a standard related to a health factor.

Accordingly, under the final rules, this wellness program would be permitted if:

- The premium differential is not more than 20 percent of the total cost of employee-only coverage (or 20% of the cost of coverage if dependents can participate in the program);
- The program is reasonably designed to promote health and prevent disease;
- Individuals eligible for the program are given an opportunity to qualify for the discount at least once per year;
- The program accommodates individuals for whom it is unreasonably difficult to quit using tobacco products due to addiction by providing a reasonable alternative standard (such as a discount in return for attending educational classes or for trying a nicotine patch); and
- Plan materials describing the terms of the premium differential describe the availability of a reasonable alternative standard to qualify for the lower premium.